No. 97-1489

In the Supreme Court of the United States

OCTOBER TERM, 1997

YOUR HOME VISITING NURSE SERVICES, INC.,
PETITIONER

v.

DONNA E. SHALALA, SECRETARY OF
HEALTH AND HUMAN SERVICES

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF FOR THE RESPONDENT

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QUESTIONS PRESENTED

1. Whether the denial of a Medicare provider's request to reopen an annual reimbursement determination under Part A of the Medicare program is subject to review under 42 U.S.C. 1395*oo*, and if not, whether the denial is subject to judicial review under 28 U.S.C. 1331 or 28 U.S.C. 1361.

2. Whether the government's position is "substantially justified" under the Equal Access to Justice Act, 5 U.S.C. 504 and 28 U.S.C. 2412.

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1-15) is reported at 132 F.3d 1135. The opinion of the district court (Pet. App. 17-33) is unreported. The decision of the Provider Reimbursement Review Board (Pet. App. 34-35) is unreported.

JURISDICTION

The judgment of the court of appeals (Pet. App. 38-39) was entered on December 22, 1997. The petition for a writ of certiorari was filed on March 11, 1998. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. In Title XVIII of the Social Security Act, Congress established the federally funded Medicare program to provide health insurance to the elderly and disabled. 42 U.S.C. 1395 *et seq.* Part A of the program provides insurance for covered inpatient hospital and related post-hospital services including certain home health services that are provided to an individual on a visiting basis in the individual's place of residence. 42 U.S.C. 1395x(m).[1] When patient beneficiaries receive covered home health services, the Secretary reimburses the providers of those services under the Medicare Act and the Secretary's implementing regulations. 42 U.S.C. 1395f(b)(1), 1395x(v)(1)(A).

A provider's total allowable Medicare payment is based on a "cost report" that it must prepare after the close of its fiscal year. 42 U.S.C. 1395g; 42 C.F.R. 405.1801(b), 413.24(f). The cost report is filed with a "fiscal intermediary" (usually an insurance company) designated by the Secretary. 42 U.S.C. 1395h. The cost report shows the provider's costs and the percentage of those costs allocated to Medicare services. 42 C.F.R. 413.20(b), 413.24(f). The intermediary analyzes the cost report, audits it if necessary, and issues the provider a written "notice of amount of program reimbursement" (NPR) containing the final determination of the total amount to be paid for Medicare services during the reporting period. 42 C.F.R. 405.1803. See *Regions Hosp.* v. *Shalala*, 118 S. Ct. 909, 913 (1998).

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[1] Part B is a voluntary supplementary insurance program covering physicians' charges and other medical services. 42 U.S.C. 1395k, 1395*l*, 1395x(s). This case arises under the Part A program.

Congress has specified in the Medicare Act itself a comprehensive scheme for administrative and judicial review of "a final determination [of a fiscal intermediary] as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under [Medicare] for the period covered by [the provider's cost] report." 42 U.S.C. 1395*oo*(a)(1)(A)(i).[2] A "dissatisfied" provider may obtain a hearing before the Provider Reimbursement Review Board (PRRB) if the amount in controversy equals or exceeds $10,000 and the provider requests a hearing "within 180 days after notice of the intermediary's determination." 42 U.S.C. 1395*oo*(a)(1)(A)(i) and (a)(3); 42 C.F.R. 405.1835; see *Bethesda Hosp. Ass'n* v. *Bowen*, 485 U.S. 399, 403-404 (1988). The Board has the authority to "affirm, modify, or reverse a final determination of the fiscal intermediary with respect to [the] cost report and to make any other revisions on matters covered by such cost report * * * even though such matters were not considered by the intermediary in making [its] final determination." 42 U.S.C. 1395*oo*(d). The Board's decision, unless modified by the Secretary, is final, and is subject to judicial review in federal district court if an action is brought within 60 days. 42 U.S.C. 1395*oo*(f)(1); 42 C.F.R. 405.1877.

By regulation, a determination by the intermediary may be "reopened" within three years (or at any time in the case of fraud) with respect to specific findings

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[2] Congress also has established administrative and judicial review procedures for individuals who are denied Medicare benefits under Part A or B of the Medicare program. See 42 U.S.C. 1395ff (incorporating procedures under 42 U.S.C. 405(b) and (g)).

at issue in the intermediary's determination, by motion of either the intermediary or the provider affected by the intermediary's determination. 42 C.F.R. 405.1885(a) and (d); see *Regions Hosp.*, 118 S. Ct. at 913.[3] The Secretary's reopening regulation also provides that "[j]urisdiction for reopening a determination or decision rests exclusively with that administrative body that rendered the last determination or decision." 42 C.F.R. 405.1885(c). The Secretary's Provider Reimbursement Manual (PRM) further explains that "[a] provider has no right to a hearing on a finding by an intermediary * * * that a reopening * * * of a determination * * * is not warranted." PRM § 2932.1. The PRM similarly states that "[a] refusal by the intermediary to grant a reopening requested by the provider is not appealable to the Board, pursuant to 42 C.F.R. § 405.1885(c)." PRM § 2926, App. A, ¶ B.4. In the event the intermediary does reopen the prior determination, however, a provider may appeal to the Board any adjustments made by the intermediary in a revised NPR. 42 C.F.R. 405.1889. The Board's decision concerning the revised NPR would then be subject to judicial review under 42 U.S.C. 1395*oo*(f)(1).

Finally, the second and third sentences of Section 205(h) of Title II of the Social Security Act, made applicable to the Medicare Act by 42 U.S.C. 1395*ii*, provide:

> No findings of fact or decision of the [Secretary] shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the [Secretary], or any officer or employee thereof shall be brought under section 1331 or 1346 of title 28 to recover on any claim arising under this subchapter.

42 U.S.C. 405(h).

[3] The regulation also authorizes the Board and the Secretary to reopen one of their respective decisions. 42 C.F.R. 405.1885(a).

2. Petitioner provides home health care services to Medicare beneficiaries and is reimbursed on a reasonable cost basis. Pet. App. 2; see 42 U.S.C. 1395f(b)(1)(A). For its 1989 fiscal year, petitioner submitted four cost reports for its home health agencies. The reports sought payment for certain compensation to its owners as an allowable cost reimbursable under the Medicare program. See 42 C.F.R. 413.102(a). On March 29, 1991, petitioner's fiscal intermediary issued four NPRs that disallowed a portion of those costs and determined the total amount of program reimbursement due to petitioners. Admin. Rec. 15-33. The NPRs also notified petitioner of its statutory right to seek review of the intermediary's determination before the PRRB within 180 days. *Id.* at 17, 20, 23, 26. Petitioner did not appeal any of the four NPRs to the PRRB within the time period specified by 42 U.S.C. 1395*oo*(a)(3). Pet. 23; Pet. App. 3.

On March 28, 1994, less than three years from the date of the issuance of the NPRs for petitioner's fiscal year 1989, petitioner requested its intermediary to reopen its final reimbursement determination for 1989 under the Secretary's reopening regulation. Admin. Rec. 12-14. Petitioner claimed that the intermediary improperly disallowed a portion of the owners' compensation costs for which petitioner sought reimbursement, because the intermediary failed to compare petitioner's costs to salary data for officers of home health agency chains. *Ibid.* The

intermediary denied the request for reopening. Pet. App. 36-37. On October 14, 1994, petitioner sought to appeal the intermediary's denial to the PRRB. Admin. Rec. 7-8. On January 10, 1995, the PRRB dismissed petitioner's appeal on the ground that it lacked jurisdiction under 42 C.F.R. 405.1885(c). Pet. App. 34-35. The PRRB concluded that, because "the Intermediary was the administrative body that rendered the last determination [on petitioner's reimbursement], it is the Intermediary's decision whether or not to reopen the cost report." *Id.* at 35.

3. Petitioner filed suit in the United States District Court for the Eastern District of Tennessee requesting that the court order the PRRB to review the intermediary's refusal to reopen its final determination for petitioner's 1989 fiscal year or, in the alternative, that the court order the intermediary to reopen petitioner's NPR to make additional payments for the claimed costs regarding owners' compensation. Compl. 6-7. The district court dismissed petitioner's complaint on the ground that the PRRB does not have jurisdiction under 42 U.S.C. 1395*oo*(a) over an intermediary's refusal to reopen a provider's NPR. Pet. App. 16-33. The court reasoned that "the Secretary's determination as reflected in the Medicare regulations and Provider Reimbursement Manual that denials of reopening requests are unreviewable is a reasonable interpretation of the Medicare statute." *Id.* at 26. The court also rejected petitioner's alternative claim that the court could review the intermediary's refusal to reopen through the exercise of either general federal question jurisdiction under 28 U.S.C. 1331 or mandamus jurisdiction under 28 U.S.C. 1361. Pet. App. 30-32.

4. The court of appeals affirmed. Pet. App. 1-15. It concluded that the language in 42 U.S.C. 1395*oo*(a) that identifies what triggers a right of review by the Board—"a final determination * * * of the intermediary * * * as to the amount of total program reimbursement due the provider"—does not clearly encompass an intermediary's denial of a request to reopen a prior determination, and that the Secretary's reopening regulation and interpretive guidelines reflect the reasonable interpretation that the statute does not grant the PRRB jurisdiction over an intermediary's denial of a request to reopen. Pet. App. 4-7. The court also found its conclusion "bolstered" by *Califano* v. *Sanders*, 430 U.S. 99, 108 (1977), in which the Court concluded that the Social Security Act, 42 U.S.C. 405(g), does not authorize federal courts to review alleged abuses in agency discretion in refusing to reopen Social Security disability claims. Pet. App. 7-8.

The court of appeals further concluded that 42 U.S.C. 405(h) precludes a district court from exercising its general federal question jurisdiction under 28 U.S.C. 1331 to review an intermediary's denial of a request to reopen, because petitioner's claims for additional reimbursement arise under the Medicare Act. Pet. App. 11-12. Finally, reasoning that a fiscal intermediary's "decision not to reopen [i]s discretionary," the court of appeals rejected petitioner's contention that the intermediary's denial of reopening is reviewable pursuant to the district court's mandamus jurisdiction under 28 U.S.C. 1361. Pet. App. 14-15.

ARGUMENT

The court of appeals correctly concluded that neither the Provider Reimbursement Review Board

nor the federal courts have jurisdiction to review the merits of a fiscal intermediary's denial of a provider's request to reopen a final Medicare reimbursement determination. We nevertheless agree with petitioner that the Court should grant certiorari in this case. The courts of appeals are divided on the question whether the Secretary reasonably construed 42 U.S.C. 1395*oo*(a) not to require the PRRB to review an intermediary's denial of a request to reopen, and the question whether such a denial is reviewable is of considerable importance to the administration of the Medicare program.

1. a. The court of appeals properly applied the two-step analysis of this Court's decision in *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842, 843 (1984), in sustaining the Secretary's interpretation of the relevant provision of the Medicare Act. See also *Regions Hosp.*, 118 S. Ct. at 915; *Thomas Jefferson Univ.* v. *Shalala*, 512 U.S. 504, 512 (1994); *Good Samaritan Hosp.* v. *Shalala*, 508 U.S. 402, 414 (1993). Section 1395*oo*(a)(1)(A)(i) authorizes the Board to review a fiscal intermediary's "final determination * * * as to the amount of total program reimbursement due the provider * * * for the period covered by [the provider's cost] report." That language plainly refers to the fiscal intermediary's issuance of the NPR reflecting the total reimbursement due the provider for that fiscal year. It does not readily encompass, however, a denial by the intermediary of a request to alter a prior determination as to whether particular cost items are reimbursable. As the court below explained:

> [T]he plain meaning of [Section] 1395*oo*(a) does not compel a holding that a reopening denial is a "final determination" of the amount of total program reimbursement. To the contrary, * * * the statute may be construed permissibly as stating that a reopening denial is a refusal to revisit the final determination. . . . [W]hile . . . a decision not to reopen is in some sense "final," it does not, in and of itself, establish an amount of total program reimbursement [as required by the statute].

Pet. App. 6-7 (quoting *Good Samaritan Hosp. Reg. Med. Ctr.* v. *Shalala*, 85 F.3d 1057, 1061-1062 (2d Cir. 1996), quoting *Good Samaritan Hosp. Reg. Med. Ctr.* v. *Shalala*, 894 F. Supp. 683, 690 (S.D.N.Y. 1995)).

Moreover, reopening is not mandated by Act but is instead authorized solely by the Secretary's reopening regulation. *HCA Health Servs. of Oklahoma, Inc.* v. *Shalala*, 27 F.3d 614, 618-619 (D.C. Cir. 1994) (Secretary promulgated reopening rules under her general rulemaking authority under 42 U.S.C. 1302 and 1395hh); see also *Regions Hosp.*, 118 S. Ct. at 913 ("By regulation, the Secretary may reopen, within three years," citing 42 C.F.R. 405.1885(a)). Thus, although Congress intended in Section 1395*oo* to authorize administrative and judicial review of the intermediary's annual determination as to the total amount of program reimbursement, the Act is silent with respect to whether, and to what extent, the denial of a request to reopen an otherwise final reimbursement determination would be permitted or subject to review.

"In light of this statutory ambiguity" (Pet. App. 7), the Secretary permissibly interpreted Section 1395*oo*(a) and her regulations not to require administrative and judicial review of an intermediary's denial of a request to reopen. A contrary interpretation

would subject the PRRB to repeated appeals of reopening denials and "frustrat[e] the congressional purpose to impose a 180-day limitation upon [PRRB] review of a fiscal intermediary's final determination on an initial cost report." Pet. App. 8.

This Court reached a similar conclusion in *Califano* v. *Sanders*, *supra*, when it held that 42 U.S.C. 405(g) did not authorize judicial review of a denial of a motion to reopen a decision of a claim for Social Security benefits. The Court observed that "the opportunity to reopen final decisions and any hearing convened to determine the propriety of such action are afforded by the Secretary's regulations and not by the Social Security Act." 430 U.S. at 108. "Moreover," the Court reasoned, "an interpretation that would allow a claimant judicial review simply by filing —and being denied—a petition to reopen his claim would frustrate the congressional purpose, plainly evidenced in [42 U.S.C. 405(g)], to impose a 60-day limitation upon judicial review of the Secretary's final decision on the initial claim for benefits." *Ibid.* Similarly, in construing Section 1395*oo*(a) not to provide for review of a denial of request to reopen under the Medicare program, the Secretary reasonably adopted a "policy * * * obviously designed to forestall repetitive or belated litigation of stale eligibility claims." 430 U.S. at 108.

b. The court of appeals also correctly concluded that the district court lacked jurisdiction under 28 U.S.C. 1331 to review the intermediary's refusal to reopen its otherwise final determination. Section 405(h), which is expressly incorporated into the Medicare Act by 42 U.S.C. 1395*ii*, prohibits federal courts from exercising jurisdiction under 28 U.S.C. 1331 to hear "'all claim[s] arising under' the Medicare

Act." *Heckler* v. *Ringer*, 466 U.S. 602, 614-615 (1984) (quoting 42 U.S.C. 405(h)); see also *Califano* v. *Sanders*, 430 U.S. at 103 n.3; *Weinberger* v. *Salfi*, 422 U.S. 749, 760-761 (1975). Because petitioner seeks a review of the intermediary's refusal to reopen petitioner's NPR for fiscal year 1989 or, alternatively, an increase in its reimbursement for owners' compensation costs, petitioner's claims plainly arise under the Medicare Act and may not be pursued under 28 U.S.C. 1331.

In arguing to the contrary, petitioner principally relies (Pet. 9-22) on this Court's decision in *Bowen* v. *Michigan Academy of Family Physicians*, 476 U.S. 667 (1986). In that case, the Court concluded that a federal court had jurisdiction under 28 U.S.C. 1331 to review a challenge to the validity of a Medicare regulation governing payments to physicians under Part B of the Medicare program. At that time, Section 1395ff provided for a hearing and judicial review of challenges to payments made under Part A but not Part B of the program. See 476 U.S. at 674 n.5 (quoting 42 U.S.C. 1395ff (1982)). The Court concluded that neither 42 U.S.C. 405(h) nor 42 U.S.C. 1395ff(b) (as it then existed) precluded "challenges mounted against the *method* by which [the] amounts [of Part B benefits] are to be determined rather than the *determinations* themselves." 476 U.S. at 675.

Contrary to the situation at issue in *Michigan Academy*, petitioner does not challenge a methodology for computing Medicare payments under Part B that would otherwise be immune from judicial review. Instead, Section 1395*oo* explicitly grants providers a right to challenge an intermediary's determination under Part A as to the amount of Medicare reimbursement owed to the provider in a given cost year.

Like the claimant in *Califano*, petitioner had such review available to it, but failed to exercise its rights under the Act. Indeed, after Congress in October 1986 amended Section 1395ff to provide for administrative and judicial review of challenges to payments made under Part B of the Medicare program, Pub. L. No. 99-509, § 9341(a)(1)(B), 100 Stat. 2037, lower courts have held that federal courts lack jurisdiction under 28 U.S.C. 1331 to review any claim arising under Part B of the program, including the type of methodology disputes at issue in *Michigan Academy*. See *Farkas* v. *Blue Cross and Blue Shield of Mich.*, 24 F.3d 853, 859-861 (6th Cir. 1994); *Abbey* v. *Sullivan*, 978 F.2d 37, 41-44 (2d Cir. 1992); *National Kidney Patients Ass'n* v. *Sullivan*, 958 F.2d 1127, 1130-1134 (D.C. Cir. 1992), cert. denied, 506 U.S. 1049 (1993). Accordingly, this Court's decision in *Michigan Academy* does not support petitioner's position in this case.

c. Finally, the court of appeals correctly concluded that a decision whether to reopen a final determination is not subject to a federal court's mandamus jurisdiction under 28 U.S.C. 1361. Pet. App. 13-14. Although this Court has declined to decide whether Section 405(h) precludes federal mandamus jurisdiction under 28 U.S.C. 1361, the Court has concluded that such jurisdiction is appropriate under the Medicare program "only if the defendant owes [the plainiff] a clear nondiscretionary duty." *Heckler* v. *Ringer*, 466 U.S. at 616. That requirement is not met in this case. On its face, the Secretary's reopening regulation vests the intermediary—the "administrative body that rendered the last determination"—with "exclusive[]" jurisdiction to decide whether to reopen its own prior determination. 42 C.F.R. 405.1885(c). Moreover, the regulation employs discretionary language when it provides that "[a] determination of an intermediary * * * *may* be reopened * * * by such intermediary * * * on motion of the provider affected by such determination." 42 C.F.R. 405.1885(a) (emphasis added). Accordingly, the court of appeals properly concluded that federal courts lack mandamus jurisdiction over a denial of a request to reopen.

2. a. Although the decision of the court of appeals is correct, we agree with petitioner that the Court should grant certiorari in this case. In addition to the Sixth Circuit in this case, the Second Circuit held in *Good Samaritan Hospital Regional Medical Center* v. *Shalala*, 85 F.3d 1057, 1060-1062 (1996), that the Secretary reasonably construed 42 U.S.C. 1395oo(a) and 42 C.F.R. 405.1885 to preclude review of an intermediary's denial of a request to reopen a prior determination. Similarly, the D.C. Circuit has stated that reopening denials under 42 C.F.R. 405.1885 are unreviewable. See *Athens Community Hosp.* v. *Schweiker*, 743 F.2d 1, 4 n.4, 8 (1984), and *St. Mary of Nazareth Hosp. Ctr.* v. *Schweiker*, 741 F.2d 1447, 1449 (1984).[4] By contrast, the Ninth Circuit held in *State of Oregon* v. *Bowen*, 854 F.2d 346, 349 (1988), that

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[4] In *HCA Health Services of Oklahoma, Inc.*, *supra*, the D.C. Circuit upheld the Secretary's position that the PRRB's jurisdiction to review the result of a reopening is limited to the specific issues revised in the reopening. 27 F.3d at 619-622. In reaching that conclusion, the D.C. Circuit reasoned that "[t]he language of the Statute itself * * * leaves us in a quandary as to whether a reopening is a 'final determination . . . as to the amount of total program reimbursement due the provider, within the meaning of [Section] 1395oo(a)(1)(A)(i), to which the rights for Board review under subsections 1395oo(a) and (d) should apply." 27 F.3d at 618-619.

"[t]he plain meaning of Section 1395*oo*(a) entitles [providers] to Board review" of an intermediary's decision denying a request to reopen. The Ninth Circuit reasoned that the intermediary's denial is a final determination that "directly implicate[s] 'the amount of total program reimbursement due the provider for items and services furnished.'" 854 F.2d at 349 (quoting 42 U.S.C. 1395*oo*(a)(1)(A)(i)).[5] Because the Ninth Circuit concluded that the Secretary's construction of the Act fails under the first-step of the *Chevron* analysis, the decision in *State of Oregon* directly conflicts with the instant decision and the decision of the Second Circuit in *Good Samaritan Regional Hospital Medical Center*.[6]

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[5] The Ninth Circuit also reasoned that the Secretary's reopening regulation was mandated by 42 U.S.C. 1395x(v)(1)(A)(ii), which authorizes the Secretary to issue regulations that "provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive." See 854 F.2d at 349. The Ninth Circuit subsequently concluded, however, that its construction of Section 1395x(v)(1)(A)(ii) in *State of Oregon* has been "undercut" by this Court's decision in *Good Samaritan Hosp.* v. *Shalala*, 508 U.S. at 414-420, which held that the Secretary reasonably construed Section 1395x(v)(1)(A)(ii) narrowly to refer only to the year-end book-balancing of monthly estimated payments to providers mandated under 42 U.S.C. 1395g with the final post-audit amounts determined to be reimbursable under the Act and the Secretary's regulations. See *French Hosp. Med. Ctr.* v. *Shalala*, 89 F.3d 1411, 1418 n.8 (9th Cir. 1996).

[6] Contrary to petitioner's assertion (Pet. 6), the Eighth Circuit's decision in *Hennepin County Medical Center* v. *Shalala*, 81 F.3d 743 (1996), does not bear on the question presented. That case involved an intermediary's decision to reopen a final determination. See 81 F.3d at 746.

Although there is no conflict among the courts of appeals over the question whether federal courts may review a denial of reopening under 28 U.S.C. 1331 or 1361, at least one district court has indicated that such review is authorized. *Memorial Hosp.* v. *Sullivan*, 779 F. Supp. 1410, 1412 (D.D.C. 1991). Moreover, the court of appeals in this case decided those issues and, therefore, we believe it would be appropriate for the Court to resolve those questions in connection with its resolution of whether the Secretary reasonably interpreted Section 1395*oo*(a) not to require review of an intermediary's decision not to reopen an otherwise final determination. Only by doing so could the Court assure a comprehensive resolution of the availability of judicial review.[7]

b. The reviewability of denials of requests to reopen presents an important and recurring issue in the administration of the already overburdened Medicare program.[8] Currently, approximately 38,000 providers

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[7] Neither court below addressed petitioner's contention (Pet. i) that 5 U.S.C. 706 independently grants subject matter jurisdiction over refusals to reopen. The Court in *Califano* v. *Sanders*, 430 U.S. at 107, however, held that the Administrative Procedure Act "does not afford an implied grant of subject-matter jurisdiction permitting federal judicial review of agency action." Petitioner's further argument (Pet. i, 21, 24-25) that denying judicial review of denials of reopening would violate its due process rights was not raised below. We therefore do not believe that contention should be considered by the Court. See, *e.g. Youakim* v. *Miller*, 425 U.S. 231, 234 (1976) (per curiam); *Auer* v. *Robbins*, 117 S. Ct. 905, 912 (1997); *Citizens Bank of Maryland* v. *Strumpf*, 516 U.S. 16, 21 n.* (1995).

[8] We have been informed by the Health Care Financing Administration in the Department of Health and Human Ser-

nationwide (and 5,400 in the Ninth Circuit, where *State of Oregon* controls) receive annual NPRs reflecting an intermediary's determination as to the total amount of Medicare reimbursement due the provider. Each of those NPRs relates to thousands of reimbursement determinations that may be subject to a subsequent request by the provider to reopen under 42 C.F.R. 405.1885.[9] The existence of a right to appeal the denial of a request to reopen any of those thousands of determinations should not depend on the fortuity of the State in which the provider resides. Thus, this Court's resolution of the reviewability issue is warranted.

3. Petitioner also requests (Pet. 22-25) that this Court grant certiorari to decide whether the Secretary's position in this case is "substantially justified" under the Equal Access to Justice Act (EAJA), 5 U.S.C. 504 and 28 U.S.C. 2412. There is no basis for review of that issue. Petitioner has not filed a fee application in this case and, because the Secretary prevailed below, neither the district court nor the court of appeals had occasion to address the question whether the Secretary's position should be regarded as substantially justified if petitioner had prevailed. Even were the Court to resolve the merits of this case in petitioner's favor, the fact-bound question of

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vices that, at the present time, the PRRB has a backlog of 10,000 cases.

[9] The Secretary estimates that, at any given time, the PRRB has pending before it approximately 20 appeals of reopening denials by providers located in the Ninth Circuit. Moreover, providers in other circuits that have not resolved the issue continue to challenge denials of reopenings. See, *e.g.*, *St. Vincent Health Ctr.* v. *Shalala*, 937 F. Supp. 496 (W.D. Pa. 1995), aff'd, 96 F.3d 1434 (3d Cir. 1996) (Table).

whether petitioner is entitled to any EAJA fees is more appropriately addressed by the district court in the first instance. See *Pierce* v. *Underwood*, 487 U.S. 552, 560 (1988).

CONCLUSION

The petition for a writ of certiorari should be granted, limited to the question whether the denial of a Medicare provider's request to reopen an annual reimbursement determination under the Medicare program is subject to review under 42 U.S.C. 1395*oo*, 28 U.S.C. 1331, or 28 U.S.C. 1361.

Respectfully submitted.

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